THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-015264
STATE FILE NUMBER

FILED MAY 14 1959 Registration District No. ____ Primary Registration District No. ____ Registrar's No. 2 4271

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST.LOUIS,MO. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST.LOUIS CITY HOSP. #1. — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY
c. CITY OR TOWN: St.Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4242 Pleasant St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First JULIUS — Middle GEORGE — Last KOLF

4. DATE OF DEATH: Month APRIL — Day 30, — Year 1959

5. SEX	6. COLOR OR RACE	7. MARRIED / WIDOWED / NEVER MARRIED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	MARRIED ☒	Sept.1, 1897	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country)	12. CITIZEN OF WHAT COUNTRY?
Mailer	Globe Democrat	St.Louis,Mo.	U.S.A.

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Peter Kolf	Margaret Thoma	Mabel Kolf nee Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes W.W.#1	494-09-0367	Mabel Kolf	4242 Pleasant St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal Hemorrhage
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Bleeding gastric ulcer
DUE TO (c): 540.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Status Postoperative w/lge resection gastric ulcer

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 4/17/59 to 4/30/59 and last saw her/him alive on 4/30/59
Death occurred at 10:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)	22b. ADDRESS	22c. DATE SIGNED
Ray Williams, M.D.	1515 LAFAYETTE AVE.	4/30/59

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Removal	5-4-59	National Cemetery	Jefferson Barracks, Mo.

24. FUNERAL DIRECTOR	ADDRESS	25. DATE RECD. BY LOCAL REG.	26. REGISTRAR'S SIGNATURE
Witt Bros. L&U.Co.	2929 S.Jefferson Ave	MAY 1 '59	Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Harold C. Wirth

Licensed Embalmer No. 4353

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.